

Massage Intake Form

Your information will be kept private and confidential.

Name: _____ Date of Birth: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Phone: (Cell) _____ (Home) _____ (Work) _____

Emergency Contact: _____ Phone: _____

How did you hear about me (if you were referred by a friend, please list their name*)? _____

_____ *When you refer a friend, you get 50% off your next massage!

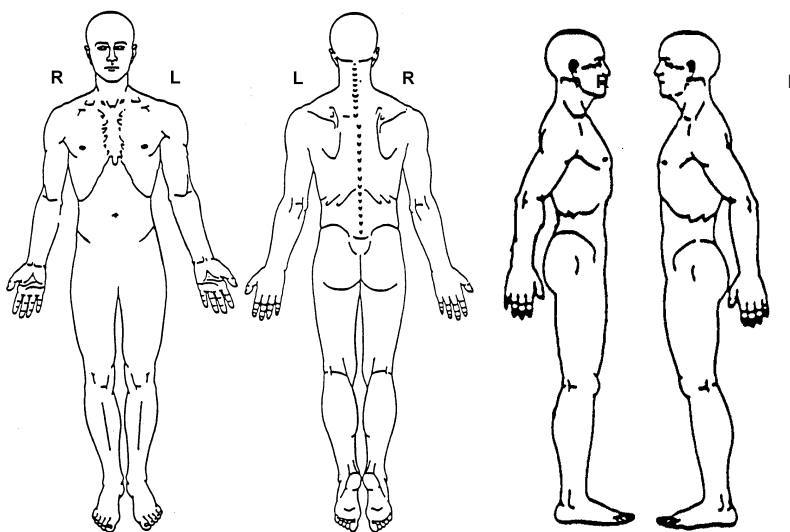
Have you had a professional massage before? Y / N If YES, when was your last massage? _____

Please state any specific goal you have for your massage treatment (i.e., relaxation, decrease back pain, increase flexibility, etc.): _____

Preferred depth of pressure (circle one): Light Medium Deep Depends where Not sure

Please list any areas that you would prefer *not* to be massaged (i.e., feet, scalp, face, abdomen, glutes, etc.): _____

Please indicate with an (X) any areas of the body where you are currently experiencing pain or discomfort:



Please describe your pain/discomfort (onset, severity, frequency, movements that cause aggravation, etc.):

Please list any broken bones, fractures, sprains, strains, injuries, or surgeries within the last 5 years:

Please list any medications that you are currently taking: _____

Are you currently under the care of a physician, chiropractor or physical therapist? Y / N

If YES, please explain: _____

IMPORTANT - Please check any of the following medical conditions that apply to you in the past or present:

| Condition/Complaint | Now | Past | Comment: | Condition/Complaint | Now | Past | Comment: |
|---------------------------------|-----|------|----------|-------------------------------|-----|------|----------|
| Skin Conditions / Rash | | | | Neuropathy ("Pins & Needles") | | | |
| Cancer / Chemotherapy | | | | Neurological Conditions | | | |
| Blood Clots / DVT | | | | Whiplash / MVA | | | |
| Cardiovascular Disease | | | | Headaches / Migraines | | | |
| High/Low BP | | | | Osteoporosis | | | |
| Varicose Veins | | | | Sciatica | | | |
| Stroke / Heart Attack | | | | Dizziness or Fainting Spells | | | |
| Herniated/Bulging Discs | | | | AIDS / HIV | | | |
| Rheumatoid Arthritis | | | | Fibromyalgia | | | |
| Osteoarthritis | | | | Epilepsy or Seizures | | | |
| Scoliosis | | | | Swelling / Inflammation | | | |
| Bursitis / Tendonitis | | | | Plantar Fasciitis | | | |
| TMJ | | | | Carpal Tunnel Syndrome | | | |
| Depression / Anxiety | | | | Chronic Muscle/Joint Pain | | | |
| Pregnancy | | | | Gout | | | |
| Allergies to scents, oils, etc. | | | | Lymphedema | | | |
| Other Allergies | | | | Other: | | | |

Please provide further explanation of any condition you checked:

Please share any other information (concerns, preferences, musical taste, etc.) that could help me make your massage more comfortable/therapeutic for you:_____

THANK YOU! A massage therapy session is an experience jointly created by the therapist and the client. I will listen and respond to your words, and to the tissues in your body, to create a safe, healthy and supportive experience that encourages stress relief, body awareness and pain reduction. All sessions are client-centered; my highest priority is your comfort and well-being.

Informed Consent for Treatment

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to notify the therapist of any changes to my health. If I experience any pain/discomfort or would like the pressure adjusted during a session, I agree to inform the therapist immediately. I understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, or to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I understand that massage therapy is non-sexual in nature and any inappropriate advance made will terminate the massage. I understand that payment for service is due and payable at the time of visit. If I am unable to make a scheduled appointment, I agree to cancel within 24 hours, unless I have an emergency. If I miss a scheduled appointment without giving 24 hours notice, I agree to pay for the full cost of the missed session. I understand that if I arrive late for an appointment, the session will end at the original scheduled time to prevent penalizing another client. It is my choice to receive massage therapy and I give consent to receive treatment.

Print Name: _____ Signature: _____ Date: _____